

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12497

12503

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>				c. LENGTH OF STAY in 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>123 Peachblossom Ave</u>				d. STREET ADDRESS <u>123 Peachblossom, Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>G.</u> Last <u>Adams</u>				4. DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/24/1889</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Route Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Route Salesman</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Geo. E. Adams</u>				14. MOTHER'S MAIDEN NAME <u>Lennie Mears</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Le Compte Funeral Service, Cambridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma liver</u> <u>155.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(primary)</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Diagnosed during surgical operation</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>59</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				20g. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that I attended the deceased from <u>9/6</u> , 19 <u>59</u> , to <u>11/19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/19</u> , 19 <u>59</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>104 Locust St</u> DATE SIGNED <u>11/20/59</u> ACTUAL SIGNATURE <u>W.H. Hanks</u> M.D. <u> </u> PHYSICIAN'S NAME (Type) <u>W.H. HANKS</u> <u>CAMBRIDGE Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u>				42a. REC'D BY REGISTRAR <u>NOV 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 6252 11-16-59 et

CERTIFICATE OF DEATH

12510

12498

Reg. Dist. No.

1. PLACE OF DEATH a. DORCHESTER b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 809 MARYLAND AVE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 CAMBRIDGE d. STREET ADDRESS 809 MARYLAND AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First KATE Middle CHRISTOPHER Last BRADLEY				4. DATE OF DEATH Month NOV. Day 9 Year 19 59			
5. SEX FMAL		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 27, 1876	
9. AGE (In years and birthday) yrs. 83		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME ROBERT CHRISTOPHER			
14. MOTHER'S MAIDEN NAME CATHERINE CHRISTOPHER				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. UNKNOWN				17. INFORMANT ROBERT PARHAM Address CAMBRIDGE MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of rectum 154x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with metastases DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from April 10, 1958 , to Nov. 9, 1959 , that I last saw the deceased alive on Nov. 7, 1959 , and that death occurred at 2 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Lewis M. Burdette M.D. 1 Locust St.				DATE SIGNED _____			
PHYSICIAN'S NAME (Type) Lewis M. Burdette Cambridge, Md				22a. BURIAL, CREMATION, REMOVAL (Specify) _____			
22b. DATE THEREOF NOV. 11, 1959				22c. NAME OF CEMETERY OR CREMATORY GREENLAWN CEMETERY			
22d. LOCATION (City, town, or county) CAMBRIDGE (State) MARYLAND				23. FUNERAL DIRECTOR'S SIGNATURE I.E. COMPTE FUNERAL SERVICE ADDRESS CAMBRIDGE MARYLAND			
24a. REC'D BY REGISTRAR NOV 10 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Kenna			

1918

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

CERTIFICATE OF DEATH

1918

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PREVIOUS ILLNESS</p> <p>12. CAUSE OF DEATH</p> <p>13. PLACE OF DEATH</p> <p>14. TIME OF DEATH</p> <p>15. SIGNATURE OF PHYSICIAN</p> <p>16. SIGNATURE OF REGISTRAR</p> <p>17. SIGNATURE OF WITNESSES</p> <p>18. SIGNATURE OF DECEASED</p>		<p>19. NAME OF PHYSICIAN</p> <p>20. ADDRESS OF PHYSICIAN</p> <p>21. SIGNATURE OF PHYSICIAN</p> <p>22. NAME OF REGISTRAR</p> <p>23. ADDRESS OF REGISTRAR</p> <p>24. SIGNATURE OF REGISTRAR</p> <p>25. NAME OF WITNESSES</p> <p>26. ADDRESS OF WITNESSES</p> <p>27. SIGNATURE OF WITNESSES</p> <p>28. NAME OF DECEASED</p> <p>29. ADDRESS OF DECEASED</p> <p>30. SIGNATURE OF DECEASED</p>
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THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD.

RECEIVED

1918

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12523

CERTIFICATE OF DEATH

12500

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY DORCHESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY DORCHESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HUDSON				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R F D CAMBRIDGE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIE Middle S. Last DAIL				4. DATE OF DEATH Month NOV. Day 11 Year 19 59			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 16, 1883	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME WILLIAM DAIL				14. MOTHER'S MAIDEN NAME MARY KEYES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216 02 6847		17. INFORMANT MRS WILLIE DAIL R D F CAMBRIDGE MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the prostate DUE TO (c) ---						INTERVAL BETWEEN ONSET AND DEATH 8 days 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus (6 years)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- -- 19 p. m. --- -- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that I attended the deceased from 6-5-59 , 19 59 , to 11-11-59 , 19 59 , that I last saw the deceased alive on 11-9-59 , 19 59 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 Locust Street, Cambridge, Md. DATE SIGNED 11-12-59							
ACTUAL SIGNATURE Eldridge H. Wolff		M.D. 15 Locust Street, Cambridge, Md. 11-12-59					
PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV. 14, 1959		22c. NAME OF CEMETERY OR CREMATORY DORCHESTER MEMORIAL PARK		22d. LOCATION (City, town, or county) (State) CAMBRIDGE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE LE COMPTE FUNERAL SERVICE				ADDRESS CAMBRIDGE MARYLAND		24a. REC'D BY REGISTRAR NOV 18 59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frame			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

277, 2001

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12501

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>15 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>253 Race St.</u>				d. STREET ADDRESS <u>253 Race St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Spencer</u> Last <u>Harris, Jr.</u>				4. DATE OF DEATH Month <u>November</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 14, 1912</u>	
9. AGE (In years last birthday) <u>47 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Petty Officer U.S. Navy</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cambridge</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>R. Spencer Harris, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes, 1935 to 1945</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>R. Spencer Harris, Sr.</u>				Address <u>3 William St., Cambridge</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dr. John Mace Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>				22b. DATE THEREOF <u>Nov. 13, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Old St. Paul's Cemetery</u>	
				22d. LOCATION (City, town, or county) <u>Chestertown, Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth R. Shuman</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 16 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

MEDICAL CERTIFICATION

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13644

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE c. LENGTH OF STAY IN 1b 7 HOURS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CAMBRIDGE MARYLAND HOSP.				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 CAMBRIDGE d. STREET ADDRESS 1 OAKLEY STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDWIN M. Middle HENRY Last 4. DATE OF DEATH Month NOV. Day 5, Year 19 59				5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH JULY 21, 1903 9. AGE (In years last birthday) 56 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICE CLERK		10b. KIND OF BUSINESS OR INDUSTRY FOOD PLANT		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME JOHN E. HENRY				14. MOTHER'S MAIDEN NAME EDNA HACKETT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) UNKNOWN		17. INFORMANT MRS EDWIN HENRY Address CAMBRIDGE MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Congestion and edema 322.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Alcohol, sparine and opiates DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 7 1/2 Hrs. 10 Hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <i>John Mace Jr.</i> EXAMINER'S NAME (Type) Dr. John Mace Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 12/9/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV. 7, 1959		22c. NAME OF CEMETERY OR CREMATORY DORCHESTER MEM. PARK		22d. LOCATION (City, town, or county) (State) CAMBRIDGE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE LE COMPTE FUNERAL SERVICE ADDRESS CAMBRIDGE MARYLAND				24a. REC'D BY REGISTRAR DATE DEC 14 '59		24b. REGISTRAR'S SIGNATURE <i>Charles S. K...</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER		13. SIGNATURE OF WITNESS		14. SIGNATURE OF JURY		15. SIGNATURE OF CORONER		16. SIGNATURE OF MINISTER		17. SIGNATURE OF CLERGY		18. SIGNATURE OF OTHER		19. SIGNATURE OF OTHER		20. SIGNATURE OF OTHER		21. SIGNATURE OF OTHER		22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER		25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER		28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER		31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER		34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER		37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER		40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER		43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER		46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER		49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER		52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER		55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER		58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER		61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER		64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER		67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER		70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER		73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER		76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER		79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER		82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER		85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER		88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER		91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER		94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER		97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER		100. SIGNATURE OF OTHER	
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CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 15 1913	
PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SPECIAL INSTRUCTIONS	
HOME		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE			
RESIDENT OF		DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		OCCUPATION	
BALTIMORE		JAN 15 1868		BALTIMORE		HIGH SCHOOL		LABORER	
MARRIED		DATE OF MARRIAGE		NAME OF SPOUSE		NAME OF FATHER		NAME OF MOTHER	
YES		JAN 15 1905		JANE HARRIS		JOHN HARRIS		MARY HARRIS	
PREVIOUS MARRIAGES		DATE OF PREVIOUS MARRIAGE		NAME OF PREVIOUS SPOUSE		NAME OF PREVIOUS FATHER		NAME OF PREVIOUS MOTHER	
NONE									
EDUCATION		OCCUPATION		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
HIGH SCHOOL		LABORER		JAN 15 1913		HOME		HEART DISEASE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE	
JAN 15 1913		HOME		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE	
MARRIED		DATE OF MARRIAGE		NAME OF SPOUSE		NAME OF FATHER		NAME OF MOTHER	
YES		JAN 15 1905		JANE HARRIS		JOHN HARRIS		MARY HARRIS	
PREVIOUS MARRIAGES		DATE OF PREVIOUS MARRIAGE		NAME OF PREVIOUS SPOUSE		NAME OF PREVIOUS FATHER		NAME OF PREVIOUS MOTHER	
NONE									
EDUCATION		OCCUPATION		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
HIGH SCHOOL		LABORER		JAN 15 1913		HOME		HEART DISEASE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12503

12514 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN b Life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS Phillips St. Ext. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Jackson		4. DATE OF DEATH Month Day Year November 30 1959	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 30, 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 10
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Roosevelt Gregory		14. MOTHER'S MAIDEN NAME Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Shirley Mae Jackson		Address Phillips St. Ext. Cambridge Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature + Immaturity (26 wks) 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 10 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Birth 11-30, 1959 , to 11-30, 1959 , that I last saw the deceased alive on 11-30, 1959 , and that death occurred at 9:55 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Eldridge H. Wolff M.D. Cambridge Maryland 12-1-59			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) Dr. Eldridge H. Wolff	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-3-59	22c. NAME OF CEMETERY OR CREMATORY Cross Road Cemetery	22d. LOCATION (City, town, or county) (State) Cambridge RDH2 - MD
23. FUNERAL DIRECTOR'S SIGNATURE Roosevelt Gregory		24a. REC'D BY REGISTRAR DATE DEC 4 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

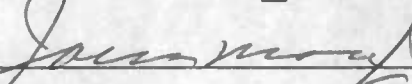
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12504

12524

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Golden Hill, Md.</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X <u>Golden Hill, Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>None</u>				d. STREET ADDRESS <u>None</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Earle</u> <u>R.</u> <u>Keene</u>				4. DATE OF DEATH Month Day Year <u>11</u> <u>18</u> <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/22/1883</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>Thomas H. Keene</u>				14. MOTHER'S MAIDEN NAME <u>Eliza E. Travers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Arthur Spicer, Golden Hill, Maryland.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>823X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto ran into creek.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>10:45</u> p.m. <u>11/18/59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Wallace Creek Nr. Golden Hill, Dor. Md.</u>			
20f. (City or town) (County) (State) <u>Golden Hill, Dor. Md.</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11/20/59</u>			
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
22b. DATE THEREOF <u>11/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Grace Church Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Taylor's Island, Maryland.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Le Compte Funeral Service Cambridge, Maryland.</u>				24a. REC'D BY REGISTRAR <u>NOV 30 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12505

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrisville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrisville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>M.</u> Last <u>Lee</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14, 1899</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Dunnock</u>		14. MOTHER'S MAIDEN NAME <u>Annie Armstrong</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-07-7309</u>	
17. INFORMANT Address <u>Levin Lee, Harrisville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Decompensation</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 13, 1959</u> , to <u>November 28, 1959</u> , that I last saw the deceased alive on <u>November 28, 1959</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>227 Pine St-Cambridge, Md. 12-1-59</u>	
PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/1/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Madison Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Madison, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 8 '59</u>	
ADDRESS <u>Cambridge, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12506

12515

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN TB 75 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge	
f. STREET ADDRESS 214 Gay Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bessie Middle Meekins Last McNamara		4. DATE OF DEATH November 9, 1959 19 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 27, 1876
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) James Island, Dor. Co.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Daniel R. Meekins		14. MOTHER'S MAIDEN NAME Sarah Ann Maguire	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Miss Elsie McNamara, 214 Gay Street, Cambridge		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 40 hrs. ?			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 11/9/59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/9/59 , 19 11/9/59 , 19 11/9/59 , that I last saw the deceased alive on 11/9/59 , 19 11/9/59 , and that death occurred at 10:55 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John Mace Jr.		ADDRESS (Street, city or town, state) Cambridge, Md. DATE SIGNED 11/10/59	
PHYSICIAN'S NAME (Type) John Mace Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF November 12, 1959	
22c. NAME OF CEMETERY OR CREMATORY Cambridge Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest R. Thomas ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE NOV 16 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

MEDICAL CERTIFICATION

VS A1S (4)
ISM 9/55

CERTIFICATE OF DEATH

Reg. Dist. No.

12508

12526

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u> 0721.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSPITAL</u>		d. STREET ADDRESS <u>248 W. MAIN</u>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>MARION LOUISE PEARCE</u>		4. DATE OF DEATH Month Day Year <u>NOVEMBER 18 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-28-12</u> 47 yrs.
9. AGE (In years last birthday) <u>47</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>	11. BIRTHPLACE (State or foreign country) <u>PENNA</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13. FATHER'S NAME <u>RALPH W. PEARCE</u>		14. MOTHER'S MAIDEN NAME <u>NELLIE P. REED</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>EASTERN SHORE STATE HOSPITAL RECORD</u>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA LEFT BREAST</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR+</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
--	--	--

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>6-24, 1959</u> to <u>11-18, 1959</u> that I last saw the deceased alive on <u>11-18, 1959</u> , and that death occurred at <u>5 AM</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>George E. Currier</u> M.D.	ADDRESS (Street, city or town, state) <u>Eastern Shore State Hospital</u>
PHYSICIAN'S NAME (Type) <u>GEORGE E. CURRIER</u> <u>Cambridge, Md.</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Nov 20, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROSEBANK CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>CALVERT, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald M. See</u>		24a. REC'D BY REGISTRAR <u>NOV 24 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1955



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12509

12527

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Vienha</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Vienna</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>			d. STREET ADDRESS <u>None</u>		
3. NAME OF DECEASED (Type or print) First <u>Guy</u> Middle <u>R.</u> Last <u>Phillips</u>			4. DATE OF DEATH Month <u>11</u> Day <u>1</u> Year <u>19</u> <u>59</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/7/1900</u>		9. AGE (In years last birthday) <u>59</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Vienna, Maryland.</u>	
13. FATHER'S NAME <u>Edgar E. Phillips</u>			14. MOTHER'S MAIDEN NAME <u>Mary V. Phillips</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. Guy R. Phillips, Vienna, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Pancreas</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>5 mos</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>5/11</u> , 19 <u>57</u> , to <u>5/11</u> , 19 <u>59</u> , that I lost saw the deceased alive on <u>11/1/59</u> , 19 <u>59</u> , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>W. H. Hanks</u>			ADDRESS (Street, city or town, state) <u>104 Locust St. Cambridge Maryland</u>		
PHYSICIAN'S NAME (Type) <u>W. H. Hanks</u>			DATE SIGNED <u>11/2/59</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/3/59.</u>	22c. NAME OF CEMETERY OR CREMATORY <u>East New Market Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>East New Market, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Maryland</u>			24a. REC'D BY REGISTRAR <u>DATE NOV 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Christina S. Hanna</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12510

12517

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 12 Hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		/d. STREET ADDRESS R.F.D. #2	
3. NAME OF DECEASED (Type or print) Kermit Leroy Pinder		4. DATE OF DEATH Month November Day 22 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 28, 1910
9. AGE (In years last birthday) yrs. 48		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming and Merchant Farm & Store		10b. KIND OF BUSINESS OR INDUSTRY Dorchester Co., Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence Pinder		14. MOTHER'S MAIDEN NAME Bertha Molock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-12-1366	
17. INFORMANT Mrs. Kermit Pinder, Cambridge, Md., R.F.D.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO 199.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-6-59 , 19____, to 11-22-59 , 19____, that I last saw the deceased alive on 11-22-59 , 19____, and that death occurred at 10:40AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 200 Maryland Avenue 11-24-59			
ACTUAL SIGNATURE Albert E. Bunker, M.D.		M.D. 200 Maryland Avenue	
PHYSICIAN'S NAME (Type) ALBERT E. BUNKER, M. D.		CAMBRIDGE, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 25, 1959	22c. NAME OF CEMETERY OR CREMATORY Fork Neck Cemetery	22d. LOCATION (City, town, or county) (State) Cambridge, Maryland, R.F.D.
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalburg, Maryland		24a. REC'D BY REGISTRAR DATE DEC 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12528

CERTIFICATE OF DEATH

Reg. Dist. No.

12511

1. PLACE OF DEATH o. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Toddville, Md.</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				d. STREET ADDRESS <u>None</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>O.</u> Last <u>Robinson</u>				4. DATE OF DEATH Month <u>11</u> Day <u>26</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/16/1887</u>		9. AGE (In years lost birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>		11. BIRTHPLACE (State or foreign country) <u>Toddville, Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>A. Robinson</u>				14. MOTHER'S MAIDEN NAME <u>M. Robinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW 1 212-16-3801</u>		17. INFORMANT <u>Mr. G. Robinson, Toddville, Maryland.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus 8 yrs.</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/3</u> , 19 <u>57</u> , to <u>11/26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/26</u> , 19 <u>59</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. H. Hanks</u>				ADDRESS (Street, city or town, state) <u>104 Locust St. Cambridge, Maryland</u>			
DATE SIGNED <u>11/28/59</u>							
PHYSICIAN'S NAME (Type) <u>W. H. HANKS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Zion Church Yard</u>		22d. LOCATION (City, town, or county) (State) <u>Toddville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

CERTIFICATE OF DEATH

1955

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 12/1/1920		6. BIRTH PLACE Jackson, Tennessee	
7. MARITAL STATUS Single		8. OCCUPATION Minister		9. EDUCATION High School	
10. DECEASED AT Baltimore, Maryland		11. PLACE OF DEATH Home		12. DATE OF DEATH 4/4/55	
13. TIME OF DEATH 10:15 AM		14. CAUSE OF DEATH Suicide		15. MANNER OF DEATH Homicide	
16. MEDICAL HISTORY None		17. PREVIOUS ILLNESS None		18. SURVIVAL None	
19. SIGNATURE OF DECEASED None		20. SIGNATURE OF WITNESS None		21. SIGNATURE OF PHYSICIAN None	
22. SIGNATURE OF CORONER None		23. SIGNATURE OF JURY None		24. SIGNATURE OF JUDGE None	
25. SIGNATURE OF CLERK None		26. SIGNATURE OF REGISTRAR None		27. SIGNATURE OF ARCHIVIST None	
28. SIGNATURE OF ASSISTANT None		29. SIGNATURE OF CHIEF None		30. SIGNATURE OF DEPUTY None	
31. SIGNATURE OF CLERK None		32. SIGNATURE OF REGISTRAR None		33. SIGNATURE OF ARCHIVIST None	
34. SIGNATURE OF ASSISTANT None		35. SIGNATURE OF CHIEF None		36. SIGNATURE OF DEPUTY None	
37. SIGNATURE OF CLERK None		38. SIGNATURE OF REGISTRAR None		39. SIGNATURE OF ARCHIVIST None	
40. SIGNATURE OF ASSISTANT None		41. SIGNATURE OF CHIEF None		42. SIGNATURE OF DEPUTY None	
43. SIGNATURE OF CLERK None		44. SIGNATURE OF REGISTRAR None		45. SIGNATURE OF ARCHIVIST None	
46. SIGNATURE OF ASSISTANT None		47. SIGNATURE OF CHIEF None		48. SIGNATURE OF DEPUTY None	
49. SIGNATURE OF CLERK None		50. SIGNATURE OF REGISTRAR None		51. SIGNATURE OF ARCHIVIST None	
52. SIGNATURE OF ASSISTANT None		53. SIGNATURE OF CHIEF None		54. SIGNATURE OF DEPUTY None	
55. SIGNATURE OF CLERK None		56. SIGNATURE OF REGISTRAR None		57. SIGNATURE OF ARCHIVIST None	
58. SIGNATURE OF ASSISTANT None		59. SIGNATURE OF CHIEF None		60. SIGNATURE OF DEPUTY None	
61. SIGNATURE OF CLERK None		62. SIGNATURE OF REGISTRAR None		63. SIGNATURE OF ARCHIVIST None	
64. SIGNATURE OF ASSISTANT None		65. SIGNATURE OF CHIEF None		66. SIGNATURE OF DEPUTY None	
67. SIGNATURE OF CLERK None		68. SIGNATURE OF REGISTRAR None		69. SIGNATURE OF ARCHIVIST None	
70. SIGNATURE OF ASSISTANT None		71. SIGNATURE OF CHIEF None		72. SIGNATURE OF DEPUTY None	
73. SIGNATURE OF CLERK None		74. SIGNATURE OF REGISTRAR None		75. SIGNATURE OF ARCHIVIST None	
76. SIGNATURE OF ASSISTANT None		77. SIGNATURE OF CHIEF None		78. SIGNATURE OF DEPUTY None	
79. SIGNATURE OF CLERK None		80. SIGNATURE OF REGISTRAR None		81. SIGNATURE OF ARCHIVIST None	
82. SIGNATURE OF ASSISTANT None		83. SIGNATURE OF CHIEF None		84. SIGNATURE OF DEPUTY None	
85. SIGNATURE OF CLERK None		86. SIGNATURE OF REGISTRAR None		87. SIGNATURE OF ARCHIVIST None	
88. SIGNATURE OF ASSISTANT None		89. SIGNATURE OF CHIEF None		90. SIGNATURE OF DEPUTY None	
91. SIGNATURE OF CLERK None		92. SIGNATURE OF REGISTRAR None		93. SIGNATURE OF ARCHIVIST None	
94. SIGNATURE OF ASSISTANT None		95. SIGNATURE OF CHIEF None		96. SIGNATURE OF DEPUTY None	
97. SIGNATURE OF CLERK None		98. SIGNATURE OF REGISTRAR None		99. SIGNATURE OF ARCHIVIST None	
100. SIGNATURE OF ASSISTANT None		101. SIGNATURE OF CHIEF None		102. SIGNATURE OF DEPUTY None	

1. NAME OF DECEASED
JAMES EARL RAY

2. SEX
Male

3. AGE
35

4. RACE
White

5. BIRTH DATE
12/1/1920

6. BIRTH PLACE
Jackson, Tennessee

7. MARITAL STATUS
Single

8. OCCUPATION
Minister

9. EDUCATION
High School

10. DECEASED AT
Baltimore, Maryland

11. PLACE OF DEATH
Home

12. DATE OF DEATH
4/4/55

13. TIME OF DEATH
10:15 AM

14. CAUSE OF DEATH
Suicide

15. MANNER OF DEATH
Homicide

16. MEDICAL HISTORY
None

17. PREVIOUS ILLNESS
None

18. SURVIVAL
None

19. SIGNATURE OF DECEASED
None

20. SIGNATURE OF WITNESS
None

21. SIGNATURE OF PHYSICIAN
None

22. SIGNATURE OF CORONER
None

23. SIGNATURE OF JURY
None

24. SIGNATURE OF JUDGE
None

25. SIGNATURE OF CLERK
None

26. SIGNATURE OF REGISTRAR
None

27. SIGNATURE OF ARCHIVIST
None

28. SIGNATURE OF ASSISTANT
None

29. SIGNATURE OF CHIEF
None

30. SIGNATURE OF DEPUTY
None

31. SIGNATURE OF CLERK
None

32. SIGNATURE OF REGISTRAR
None

33. SIGNATURE OF ARCHIVIST
None

34. SIGNATURE OF ASSISTANT
None

35. SIGNATURE OF CHIEF
None

36. SIGNATURE OF DEPUTY
None

37. SIGNATURE OF CLERK
None

38. SIGNATURE OF REGISTRAR
None

39. SIGNATURE OF ARCHIVIST
None

40. SIGNATURE OF ASSISTANT
None

41. SIGNATURE OF CHIEF
None

42. SIGNATURE OF DEPUTY
None

43. SIGNATURE OF CLERK
None

44. SIGNATURE OF REGISTRAR
None

45. SIGNATURE OF ARCHIVIST
None

46. SIGNATURE OF ASSISTANT
None

47. SIGNATURE OF CHIEF
None

48. SIGNATURE OF DEPUTY
None

49. SIGNATURE OF CLERK
None

50. SIGNATURE OF REGISTRAR
None

51. SIGNATURE OF ARCHIVIST
None

52. SIGNATURE OF ASSISTANT
None

53. SIGNATURE OF CHIEF
None

54. SIGNATURE OF DEPUTY
None

55. SIGNATURE OF CLERK
None

56. SIGNATURE OF REGISTRAR
None

57. SIGNATURE OF ARCHIVIST
None

58. SIGNATURE OF ASSISTANT
None

59. SIGNATURE OF CHIEF
None

60. SIGNATURE OF DEPUTY
None

61. SIGNATURE OF CLERK
None

62. SIGNATURE OF REGISTRAR
None

63. SIGNATURE OF ARCHIVIST
None

64. SIGNATURE OF ASSISTANT
None

65. SIGNATURE OF CHIEF
None

66. SIGNATURE OF DEPUTY
None

67. SIGNATURE OF CLERK
None

68. SIGNATURE OF REGISTRAR
None

69. SIGNATURE OF ARCHIVIST
None

70. SIGNATURE OF ASSISTANT
None

71. SIGNATURE OF CHIEF
None

72. SIGNATURE OF DEPUTY
None

73. SIGNATURE OF CLERK
None

74. SIGNATURE OF REGISTRAR
None

75. SIGNATURE OF ARCHIVIST
None

76. SIGNATURE OF ASSISTANT
None

77. SIGNATURE OF CHIEF
None

78. SIGNATURE OF DEPUTY
None

79. SIGNATURE OF CLERK
None

80. SIGNATURE OF REGISTRAR
None

81. SIGNATURE OF ARCHIVIST
None

82. SIGNATURE OF ASSISTANT
None

83. SIGNATURE OF CHIEF
None

84. SIGNATURE OF DEPUTY
None

85. SIGNATURE OF CLERK
None

86. SIGNATURE OF REGISTRAR
None

87. SIGNATURE OF ARCHIVIST
None

88. SIGNATURE OF ASSISTANT
None

89. SIGNATURE OF CHIEF
None

90. SIGNATURE OF DEPUTY
None

91. SIGNATURE OF CLERK
None

92. SIGNATURE OF REGISTRAR
None

93. SIGNATURE OF ARCHIVIST
None

94. SIGNATURE OF ASSISTANT
None

95. SIGNATURE OF CHIEF
None

96. SIGNATURE OF DEPUTY
None

97. SIGNATURE OF CLERK
None

98. SIGNATURE OF REGISTRAR
None

99. SIGNATURE OF ARCHIVIST
None

100. SIGNATURE OF ASSISTANT
None

101. SIGNATURE OF CHIEF
None

102. SIGNATURE OF DEPUTY
None

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12518

CERTIFICATE OF DEATH

12512

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OAKLEY STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MAMIE Middle PHILLIPS Last ROSZELLE				4. DATE OF DEATH Month NOV. Day 9, Year 19 59			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 28, 1888		9. AGE (In years last birthday) yrs. 71	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE			10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME LUTHER PHILLIPS				14. MOTHER'S MAIDEN NAME MARGARET MILLS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT L THURMAN PHILLIPS Address CAMBRIDGE MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Lung left. 162.1 DUE TO (Bronchogenic) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 4 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/10 , 19 55 , to 11/9 , 19 59 , that I last saw the deceased alive on 11/9 , 19 59 , and that death occurred at 12:35 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. H. Hanks M.D.				ADDRESS (Street, city or town, state) 104 LOCUST ST CAMBRIDGE MD		DATE SIGNED 11/10/59	
PHYSICIAN'S NAME (Type) W. H. HANKS							
22a. BURIAL, CREMATION, BURNING (Specify) BURNING		22b. DATE THEREOF NOV. 11, 1959		22c. NAME OF CEMETERY OR CREMATORY CAMBRIDGE CEMETERY		22d. LOCATION (City, town, or county) (State) CAMBRIDGE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE LE COMPTE FUNERAL SERVICE ADDRESS CAMBRIDGE MARYLAND				24a. REC'D BY REGISTRAR DATE NOV 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Handwritten: John Doe]		2. SEX [Handwritten: Male]	
3. AGE [Handwritten: 45]		4. DATE OF BIRTH [Handwritten: 10/15/1910]	
5. PLACE OF BIRTH [Handwritten: Baltimore, Md.]		6. OCCUPATION [Handwritten: Clerk]	
7. MARITAL STATUS [Handwritten: Married]		8. DATE OF MARRIAGE [Handwritten: 05/10/1935]	
9. NAME OF SPOUSE [Handwritten: Jane Doe]		10. DATE OF DEATH [Handwritten: 11/20/1955]	
11. TIME OF DEATH [Handwritten: 10:15 AM]		12. PLACE OF DEATH [Handwritten: Home]	
13. CAUSE OF DEATH [Handwritten: Myocardial Infarction]		14. MANNER OF DEATH [Handwritten: Natural]	
15. SIGNATURE OF PHYSICIAN [Handwritten: Dr. J. Smith]		16. SIGNATURE OF WITNESS [Handwritten: J. Doe]	
17. SIGNATURE OF DECEASED [Handwritten: John Doe]		18. SIGNATURE OF NEAREST RELATIVE [Handwritten: Jane Doe]	
19. SIGNATURE OF CLERK [Handwritten: J. Doe]		20. SIGNATURE OF REGISTRAR [Handwritten: J. Doe]	

This certificate is to be filled out by the physician or other qualified person who has attended the deceased or by the next of kin or other person who has been in attendance at the death. It should be filled out as soon as possible after death and should be filed in the office of the Registrar of the State Department of Health.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12529

CERTIFICATE OF DEATH

Reg. Dist. No.

12513

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>DORCHESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - CAMBRIDGE</u>				c. LENGTH OF STAY IN 1b <u>1 YEAR</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSP.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SECRETARY</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH FRANKLIN SHIMEK</u>				4. DATE OF DEATH Month Day Year <u>NOV. 2 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/18/1883</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>JOHN SHIMEK</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE REDOS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>			
17. INFORMANT <u>THOMAS SHIMEK</u>				Address <u>ROCK HALL, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>AUG. 1</u> , 19 <u>59</u> , to <u>NOV. 2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>NOV. 1</u> , 19 <u>59</u> , and that death occurred at <u>1:45 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>George H. Longley</u> M.D. <u>R.F.D. 2, CAMBRIDGE, MD.</u> <u>11/2/59</u>							
ACTUAL SIGNATURE <u>George H. Longley</u> PHYSICIAN'S NAME (Type) <u>GEORGE H. LONGLEY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/4/59</u>		<u>St. Mary's Cemetery</u>		<u>Secretary, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Keith S. Bullock</u>				ADDRESS <u>677 N. Market, Md</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 6 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Charles S. Kneass</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1953

DECEASED

NAME

DATE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

DECLARATION OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12519

CERTIFICATE OF DEATH

Reg. Dist. No. 12514

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Cambridge-Maryland Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>Estelle</u> Last <u>Slater</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 11, 1889</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Slater</u>		14. MOTHER'S MAIDEN NAME <u>Mary Kiah</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>146-18-8584</u>	
17. INFORMANT <u>Emma St. Clair, Cambridge, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>November 8, 1959</u> to <u>Nov. 13, 1959</u> , that I last saw the deceased alive on <u>Nov. 12, 1959</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>227 Pine St-Cambridge, Md.</u> DATE SIGNED <u>11-16-59</u>	
PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/17/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 23 '59</u>	
ADDRESS <u>Cambridge, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

12515

Reg. Dist. No.

12520

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CAMBRIDGE MARYLAND HOSP.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS HIGH STREET							
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM T. SOWERS				4. DATE OF DEATH Month Day Year NOV. 13, 19 59			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 16, 1898	9. AGE (In years last birthday) yrs. 61	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER				10b. KIND OF BUSINESS OR INDUSTRY CAMBRIDGE HIGH SCHOOL KENTUCKY		11. BIRTHPLACE (State or foreign country) U S A	
13. FATHER'S NAME JOHN SOWERS				14. MOTHER'S MAIDEN NAME MAE RISQUE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. 214 16 4880		17. INFORMANT Address MRS WILLIAM SOWERS CAMBRIDGE MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 570.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Profound shock DUE TO (c) Mesenteric thrombosis						INTERVAL BETWEEN ONSET AND DEATH 30 hours 30 hours 30 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease with chronic fibrillation						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -- -- --				
20c. TIME OF INJURY Month, Day, Year Hour a. m. -- -- 19 p. m. -- --			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -- -- --		
20f. (City or town) -- -- --			20g. (County) -- -- --			20h. (State) -- -- --	
21. I certify that I attended the deceased from 10-30-59 , 19____, to 11-13-59 , 19____, that I last saw the deceased alive on 11-13-59 , 19____, and that death occurred at 9:40AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Eldridge H. Wolff				ADDRESS (Street, city or town, state) 15 Locust Street, Cambridge, Md.			
PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.				DATE SIGNED 11-14-59			
22a. BURIAL, CREMATION, or other final disposition (Specify) BURIAL		22b. DATE THEREOF NOV. 16, 1959		22c. NAME OF CEMETERY OR CREMATORY CHRIST CHURCH CEMETERY		22d. LOCATION (City, town, or county) (State) CAMBRIDGE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE LE COMPTE FUNERAL SERVICE				ADDRESS CAMBRIDGE MARYLAND		24a. REC'D BY REGISTRAR DATE NOV 18 1959	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kram			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12516

12530

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 42yr 9mo 25days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital		e. STREET ADDRESS Chance	
3. NAME OF DECEASED (Type or print) Lester		4. DATE OF DEATH November 16 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 11, 1895
9. AGE (in years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME JOSEPH T. TARLETON		14. MOTHER'S MAIDEN NAME ESTHER P. SHRIEVES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT RECORDS: Eastern Shore State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL TUMOR 237x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASPHYXIA DUE TO ASPIRATION OF Food (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH UNDER 10 MIN.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Alfred R. Maryanov		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) ALFRED R. MARYANOV		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-19-59	
22c. NAME OF CEMETERY ROCK CREEK		22d. LOCATION (City, town, or county) (State) CHANCE MD	
23. FUNERAL DIRECTOR'S SIGNATURE Herzog H. Webster		24a. REC'D BY REGISTRAR NOV 20 1959	
ADDRESS Princess Anne		24b. REGISTRAR'S SIGNATURE William S. Kram	

TO STATE
HEALTH DEPT.

PRELIMINARY STATEMENT

STATE OF
MASSACHUSETTS
COUNTY OF
SUFFOLK
CITY OF
BOSTON

DEATH CERTIFICATE

1. Name of Deceased: ESTHER P. SHAW
2. Date of Death: 11-14-1914
3. Place of Death: Home
4. Age: 78 years
5. Sex: Female
6. Race: White
7. Marital Status: Widow
8. Occupation: None
9. Cause of Death: Senility
10. Duration of Illness: Several months
11. Name of Physician: Dr. J. W. Shaw
12. Name of Undertaker: W. J. Shaw
13. Name of Burial Place: Graveyard
14. Name of Minister of Religion: Rev. J. W. Shaw
15. Name of Health Officer: Dr. J. W. Shaw
16. Name of Registrar: Dr. J. W. Shaw
17. Name of Coroner: Dr. J. W. Shaw
18. Name of Jury: Dr. J. W. Shaw
19. Name of Jury: Dr. J. W. Shaw
20. Name of Jury: Dr. J. W. Shaw

21. Name of Deceased: ESTHER P. SHAW
22. Date of Death: 11-14-1914
23. Place of Death: Home
24. Age: 78 years
25. Sex: Female
26. Race: White
27. Marital Status: Widow
28. Occupation: None
29. Cause of Death: Senility
30. Duration of Illness: Several months
31. Name of Physician: Dr. J. W. Shaw
32. Name of Undertaker: W. J. Shaw
33. Name of Burial Place: Graveyard
34. Name of Minister of Religion: Rev. J. W. Shaw
35. Name of Health Officer: Dr. J. W. Shaw
36. Name of Registrar: Dr. J. W. Shaw
37. Name of Coroner: Dr. J. W. Shaw
38. Name of Jury: Dr. J. W. Shaw
39. Name of Jury: Dr. J. W. Shaw
40. Name of Jury: Dr. J. W. Shaw

41. Name of Deceased: ESTHER P. SHAW
42. Date of Death: 11-14-1914
43. Place of Death: Home
44. Age: 78 years
45. Sex: Female
46. Race: White
47. Marital Status: Widow
48. Occupation: None
49. Cause of Death: Senility
50. Duration of Illness: Several months
51. Name of Physician: Dr. J. W. Shaw
52. Name of Undertaker: W. J. Shaw
53. Name of Burial Place: Graveyard
54. Name of Minister of Religion: Rev. J. W. Shaw
55. Name of Health Officer: Dr. J. W. Shaw
56. Name of Registrar: Dr. J. W. Shaw
57. Name of Coroner: Dr. J. W. Shaw
58. Name of Jury: Dr. J. W. Shaw
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MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13657

12521

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Hosp. D.O.A.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe d. STREET ADDRESS R.F.D. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William First thomas Middle Last 4. DATE OF DEATH Month 11 Day 25 Year 1959		5. SEX Male 6. COLOR OR RACE Col 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 12/21/10 9. AGE (In years last birthday) 48 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER 10b. KIND OF BUSINESS OR INDUSTRY Domestic 11. BIRTHPLACE (State or foreign country) North Carolina 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown 14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. — 17. INFORMANT Mary Smith Trappe, Md Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rupture aneurysm abdominal aorta DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 11/25 1959 Hour 4 o. m. p. m. 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 50 20f. (City or town) (County) (State) Cambridge Dor. Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE John Mace Jr. EXAMINER'S NAME (Type) John Mace Jr. M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 11/30/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 12/19/59 22c. NAME OF CEMETERY OR CREMATORY Richards Cemetery 22d. LOCATION (City, town, or county) (State) Easton, Md.		23. FUNERAL DIRECTOR'S SIGNATURE James B. Doshier ADDRESS Easton, Md. 24a. REC'D BY REGISTRAR DATE DEC 10 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

MEDICAL CERTIFICATION

2

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12517

12531

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Cambridge</u>			c. LENGTH OF STAY IN 1b <u>Life</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Cambridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>R. F. D. #2</u>				d. STREET ADDRESS <u>R. F. D. #2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Thompson</u> Last <u>Thompson</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 27, 1872</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Mfg.</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Robert Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-20-6282</u>		17. INFORMANT Address <u>Charles Pinder, RFD 2, Cambridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 1</u> , 19 <u>59</u> , to <u>Nov 18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>November 18</u> , 19 <u>59</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>227 Pine St-Cambridge, Md.</u> DATE SIGNED <u>Nov 23 '59</u>							
ACTUAL SIGNATURE <u>J. Edwin Fassett</u> M.D.				PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/22/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cordtown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard M. Sullivan</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12522

CERTIFICATE OF DEATH

12518

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>14 School House Lane</u>		d. STREET ADDRESS <u>14 School House Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>E.</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>March 8, 1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jehu Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Luvenia Molock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Gretha Adams, Cambridge, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>July 26, 1958</u> , to <u>Nov 12, 1959</u> , that I last saw the deceased alive on <u>November 12, 1959</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jehu Wilson</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>227 Pine St-Cambridge, Md. 11-13-59</u>	
PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>		<u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/14/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fork Neck Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kiana</u>		ADDRESS <u>Cambridge, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. STREET ADDRESS		10. CITY		11. STATE		12. COUNTY	
13. DATE OF DEATH		14. TIME OF DEATH		15. PLACE OF DEATH		16. CAUSE OF DEATH	
17. DISEASE OR INJURY		18. MODE OF DEATH		19. PERIOD OF ILLNESS		20. PREVIOUS ILLNESS	
21. SIGNATURE OF PHYSICIAN		22. SIGNATURE OF WITNESS		23. SIGNATURE OF DECEASED		24. SIGNATURE OF FUNERAL HOME	
25. SIGNATURE OF REGISTRAR		26. SIGNATURE OF CLERK		27. SIGNATURE OF JUDGE		28. SIGNATURE OF SHERIFF	
29. SIGNATURE OF DISTRICT ATTORNEY		30. SIGNATURE OF COUNTY CLERK		31. SIGNATURE OF TOWNSHIP CLERK		32. SIGNATURE OF VILLAGE CLERK	
33. SIGNATURE OF CITY CLERK		34. SIGNATURE OF TOWNSHIP CLERK		35. SIGNATURE OF VILLAGE CLERK		36. SIGNATURE OF CITY CLERK	
37. SIGNATURE OF TOWNSHIP CLERK		38. SIGNATURE OF VILLAGE CLERK		39. SIGNATURE OF CITY CLERK		40. SIGNATURE OF TOWNSHIP CLERK	
41. SIGNATURE OF VILLAGE CLERK		42. SIGNATURE OF CITY CLERK		43. SIGNATURE OF TOWNSHIP CLERK		44. SIGNATURE OF VILLAGE CLERK	
45. SIGNATURE OF CITY CLERK		46. SIGNATURE OF TOWNSHIP CLERK		47. SIGNATURE OF VILLAGE CLERK		48. SIGNATURE OF CITY CLERK	
49. SIGNATURE OF TOWNSHIP CLERK		50. SIGNATURE OF VILLAGE CLERK		51. SIGNATURE OF CITY CLERK		52. SIGNATURE OF TOWNSHIP CLERK	
53. SIGNATURE OF VILLAGE CLERK		54. SIGNATURE OF CITY CLERK		55. SIGNATURE OF TOWNSHIP CLERK		56. SIGNATURE OF VILLAGE CLERK	
57. SIGNATURE OF CITY CLERK		58. SIGNATURE OF TOWNSHIP CLERK		59. SIGNATURE OF VILLAGE CLERK		60. SIGNATURE OF CITY CLERK	
61. SIGNATURE OF TOWNSHIP CLERK		62. SIGNATURE OF VILLAGE CLERK		63. SIGNATURE OF CITY CLERK		64. SIGNATURE OF TOWNSHIP CLERK	
65. SIGNATURE OF VILLAGE CLERK		66. SIGNATURE OF CITY CLERK		67. SIGNATURE OF TOWNSHIP CLERK		68. SIGNATURE OF VILLAGE CLERK	
69. SIGNATURE OF CITY CLERK		70. SIGNATURE OF TOWNSHIP CLERK		71. SIGNATURE OF VILLAGE CLERK		72. SIGNATURE OF CITY CLERK	
73. SIGNATURE OF TOWNSHIP CLERK		74. SIGNATURE OF VILLAGE CLERK		75. SIGNATURE OF CITY CLERK		76. SIGNATURE OF TOWNSHIP CLERK	
77. SIGNATURE OF VILLAGE CLERK		78. SIGNATURE OF CITY CLERK		79. SIGNATURE OF TOWNSHIP CLERK		80. SIGNATURE OF VILLAGE CLERK	
81. SIGNATURE OF CITY CLERK		82. SIGNATURE OF TOWNSHIP CLERK		83. SIGNATURE OF VILLAGE CLERK		84. SIGNATURE OF CITY CLERK	
85. SIGNATURE OF TOWNSHIP CLERK		86. SIGNATURE OF VILLAGE CLERK		87. SIGNATURE OF CITY CLERK		88. SIGNATURE OF TOWNSHIP CLERK	
89. SIGNATURE OF VILLAGE CLERK		90. SIGNATURE OF CITY CLERK		91. SIGNATURE OF TOWNSHIP CLERK		92. SIGNATURE OF VILLAGE CLERK	
93. SIGNATURE OF CITY CLERK		94. SIGNATURE OF TOWNSHIP CLERK		95. SIGNATURE OF VILLAGE CLERK		96. SIGNATURE OF CITY CLERK	
97. SIGNATURE OF TOWNSHIP CLERK		98. SIGNATURE OF VILLAGE CLERK		99. SIGNATURE OF CITY CLERK		100. SIGNATURE OF TOWNSHIP CLERK	

ARTICLE OF INCORPORATION

FOR THE CITY OF BALTIMORE

IN THE YEAR 1800

THE CITY OF BALTIMORE

DO HEREBY CERTIFY

THAT THE ABOVE

IS A TRUE AND

CORRECT COPY

OF THE ARTICLES

OF INCORPORATION

AS THE SAME

STAND RECORDED

IN THE OFFICE

OF THE CLERK

OF THE CITY

OF BALTIMORE

THIS 10TH DAY

OF MAY 1900

AT BALTIMORE

MARYLAND